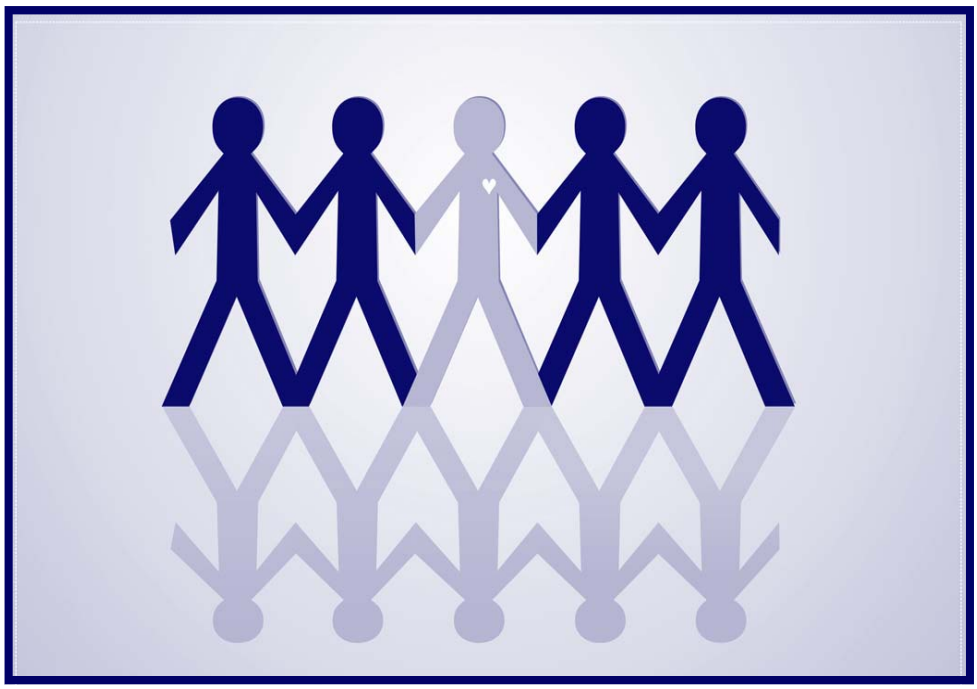

Person-Centered Planning

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Instruction Manual

July 2007

Division of MH/DD/SAS

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PERSON-CENTERED PLANNING INSTRUCTIONS
(REVISED)
7/11/07

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PERSON-CENTERED PLANNING INSTRUCTIONS (REVISED) 7/11/07

I. OVERVIEW

The State Plan: A Blueprint for Change establishes person-centered planning as fundamental to transformation within the mental health/developmental disability/substance abuse service system. Person-centered planning is a process of determining real-life outcomes with individuals/families and developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to ***everyone*** supported and served in the system. Person-centered planning provides for the individual with or family of a child with a disability assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability, and his/her family, or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made. For children and families, a Child and Family Team (CFT) is the vehicle for person-centered planning.

The Key Values and Principles Serving as the Foundation of Person-Centered Planning are:

1. Person-centered planning builds on the individual's/family's strengths, gifts, skills, and contributions.
2. Person-centered planning supports personal empowerment, and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals, and aspirations.
3. Person-centered planning is a framework for providing services, treatment, supports and interventions that meet the individual's/family's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
4. Person-centered planning supports a fair and equitable distribution of system resources.
5. Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.
6. Person-centered planning sees individuals/families in the context of their culture, ethnicity, religion and gender. All the elements that compose a person's individuality and a family's uniqueness are acknowledged and valued in the planning process.
7. Person-centered planning supports mutually respectful partnerships between individuals/families and providers/professionals, and recognizes the legitimate contributions of all parties.

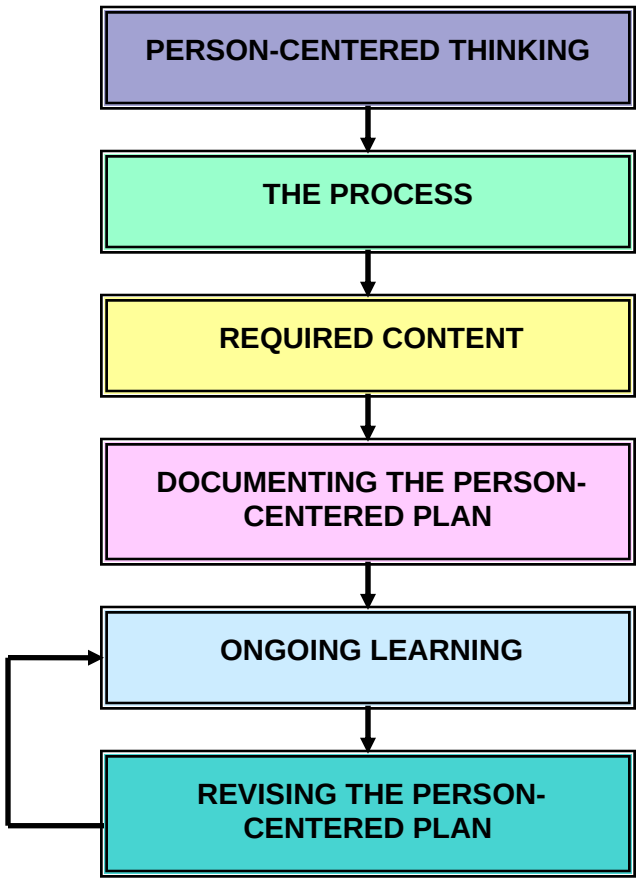
The Person-Centered Plan as a Unified Life Plan

The Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. It focuses on the identification of the individual's/family's needs and desired life outcomes--not just a request for a specific service. The plan captures all goals and objectives and outlines each team member's responsibilities within the plan. This plan is based on preferences and strengths for individuals identified by people who know and care about the person, which then supports good action and crisis planning. Natural and community supports should always be considered within all person-centered plans.

Child and Family Teams

In the case of children and youth, the person-centered planning process is a function of a Child and Family Team (CFT). A Child and Family Team is a group of people selected by the family that includes natural and community supports and any public and private child serving agencies that are or may need to be involved. This includes, but is not limited to: juvenile justice, child welfare, schools, public health, or other mental health, substance abuse or developmental disability providers. A Child and Family Team meeting identifies strengths, needs, goals/family-driven outcomes, and outlines an action plan for all team members.

II. THE FRAMEWORK FOR DEVELOPING A PERSON-CENTERED PLAN



A. PERSON-CENTERED THINKING

For people/families receiving mh/dd/sa supports and services, it is not person-centered planning that matters as much as the pervasive presence of person-centered thinking.

- If people/families who use services are to have self directed lives within their own communities, then those who play a primary role in facilitating service plans and providing services and supports need to have person-centered thinking skills.
- Person-centered thinking is a set of value-based skills that change the way we see individuals/families, change the way we support individuals/families, set the stage for ongoing learning about individuals/families and acting upon that learning.

Learning and supporting the use of person-centered thinking skills result in:

- Plans being developed that are used and acted on, so that the lives of people who use services will improve.
- Several ways to get plans started/revised/updated.
- Plans that occur 'naturally', needing less effort and time.

B. THE PROCESS

Person- Centered Planning is a process. This process enables people important to the person, as well as people that will provide supports and services to come together and state who, what, when, and where services will be offered. It is recognized that each plan will reflect the degree of information available/known at any given time. Therefore, information will continue to be gathered and added as more learning takes place.

The Person-Centered Planning process will utilize:

- **Information Gathering:**
  - The planning process may include one or more dialogues with the person to whom the plan belongs, and any others identified by this individual.
  - The dialogues are initiated by the person responsible for writing the PCP (the QP). Dialogues may be formal or informal meetings, telephone conversations, any discussion used to gather needed information.
  - The QP from any service that meets the designation of clinical home will be responsible for gathering information to develop the PCP. In some services the QP may be a licensed professional (LP), while others are those that meet the QP requirements in core rules.
  - Discussions within the dialogues/meetings should include information about aspirations and goals.
  - Decisions are made by the individual/family/legally responsible parties and professionals working together to determine services, supports and treatment, including natural and community resources, that can best meet the person's identified desires and needs.

- **Unified Planning:** Since the person-centered plan is the umbrella under which all planning for support and treatment occurs, all facets of support/treatment representing the individual's aspirations and goals must be documented within it. All resources, including natural and community, are to be included in the plan.

  - When agreed upon by the person and other planning participants, separate goals and supports/interventions may be developed by a provider for a specific service; however
  - Specialized sets of goals must be integrated into the unified person-centered plan by the QP/LP.
  - When specialized service-specific goals are not included initially, they may be added when needed, as an update/revision to the plan.

- **Separate plans may not be developed by individual providers.**
  Person-centeredness can only be assured by integrating all goals into one document, verifying that they emanate from the information gathered during discussions and documented in the Interview Sections of the PCP. Providers may participate in the planning process by:

  - Attending a full treatment team meeting meant to develop goals,
  - Receiving copies of the information gathered during dialogues to use to develop goals and then submit them to the PCP writer
  - Contacting the PCP writer by phone to discuss specialized service goals needed.
  - Any other way as described above in Information Gathering.
  - **Remember: Nothing should be added to a PCP without agreement from the individual/family/legally responsible person.**
  - The person responsible for the PCP (the QP/LP), must ensure that all other providers documented in the plan receive a copy of the plan that includes all the appropriate signatures.

The Person-Centered Planning process will utilize:

- **<u>Authorization</u>:**
  - After the person-centered plan is completed, the QP/LP submits the plan to the identified service authorization agency for review.
  - The service authorization agency reviews the person-centered plan to ensure that medical necessity has been met for the requested treatment/services.
  - *Please refer to Section C below for specific information on first authorizations and ongoing authorizations.*

C. REOUIRED CONTENT

An <u>Introductory PCP</u> is a plan for an individual who is new to the mh/dd/sa system. Use of an Introductory PCP allows the provider to quickly gather the information needed to request authorization from the service authorization agency.

- A person new to the mh/dd/sa system, per the description above, may be referred to an appropriate service through a Screening/Triage/Referral (STR) process, or may directly contact any provider agency of their choosing for appropriate services.

- An Introductory PCP must be completed by a QP/LP from the chosen provider for any of the following services:
  - Assertive Community Treatment Team **(ACTT)**
  - Community Support – Adult **(CS) – 8 hours unmanaged Medicaid**
  - Community Support – Child **(CS) – 8 hours unmanaged Medicaid**
  - Community Support Team **(CST)**
  - Intensive In-Home **(IIH)**
  - Multisystemic Therapy **(MST)**
  - Substance Abuse Comprehensive Outpatient Treatment **(SACOT)**
  - Substance Abuse Intensive Outpatient Program **(SAIOP)**
  - Targeted Case Management **(TCM) – 8 hours unmanaged Medicaid**

- **When the result of Screening/Triage/Referral or direct contact by the individual** is any service above other than CS/TCM, pre-authorization must be received from the service authorization agency before any billing may occur.

- **If CS or Targeted Case Management is the chosen service,** the QP may bill up to 8 hours of CS/TCM services while gathering information and completing the Introductory PCP for submission to the service authorization agency for service authorization. This allows a short window of time for the CS/TCM QP to work with the consumer and his/her family to determine what service(s) may be appropriate for the individual. The 8 hours of pass through CS/TCM services is a once in the lifetime event.

- **The following elements constitute the documents required to process an Introductory PCP and initial authorization:**
  - PCP pages required:
    1) **Action Plan** page(s) from the PCP
    2) **Crisis Prevention/Crisis Response (Continuation)** page of the PCP (the 2nd page of the Crisis Plan reflecting contact and other information
    3) **Signature Page** from the PCP including:
       a. Confirmation of Medical Necessity / Service Order dated signature
       b. Person Receiving Services dated signature (required when the person is his/her own legally responsible person.
       c. Legally Responsible Person dated signature when the person receiving services is not his/her own LRP.
       d. Person Responsible for the Plan dated signature.
  - Inpatient Treatment Report (ITR)
  - Consumer Admission Form (for submission to the LME)

AUTHORIZATION & FOLLOW-UP PROCESS

- **When any service listed above is authorized (Community Support/Targeted Case Management), or pre-authorized (all other services) by the service authorization agency:**
  - The authorization is in effect for the duration indicated by the service authorization agency, per the service definition or Implementation Updates.
  - Prior to the end of the first authorization period, the following must be completed and submitted to the service authorization agency for any further authorization to occur:
    1) New ITR
    2) Complete PCP
  - Prior to the end of the first authorization period, a Comprehensive Clinical Assessment must be completed, but is not submitted to the service authorization agency.

  - **The Comprehensive Clinical Assessment may include but is not limited to:**
    1) T1023-Diagnostic Assessment
    2) 90801-Clinical Evaluation/Intake
    3) 90802-Interactive Evaluation
    4) 96101-Psychological Testing
    5) 96110-Developmental Testing (Limited)
    6) 96111-Developmental Testing (Extended)
    7) 96116-Neuropsychological Exam
    8) 96118-Neuropsychological Testing Battery
    9) H-0001-Alcohol &/or Drug Assessment
    10) H-0031-Mental Health Assessment
    11) Evaluation & Management (E/M) Codes
    12) YP830-Alcohol &/or Drug Assessment-non-licensed provider (State $ only)
    13) YP836-Mental Health Assessment-non-licensed provider (State $ only)

  - **Required Content for a Complete PCP will include the following PCP pages:**
    1) Participants Involved in Complete Plan Development
    2) Personal Dialogue/Interview
    3) Family, Legally Responsible Person, Informal Supports Dialogue/Interview
    4) Service/Provider Dialogue/Interview
    5) Summary of Assessments and Observations
    6) Action Plan and Action Plan/Continuation
    7) Crisis Prevention/Crisis Response
    8) Crisis Prevention/Crisis Response (Continuation)
    9) Comments and Signatures

- **No additional authorizations will be granted based on an Introductory PCP.**

- **All of the pages of the PCP described in the remainder of this document constitute the Complete PCP.**

D. DOCUMENTING THE PERSON-CENTERED PLAN

***IMPORTANT* (Please read before proceeding to the next sections of the instruction manual)**

One of the essential concepts within person-centered thinking is that of understanding the balance between what is **"Important TO"** and **"Important FOR"** the person/family to whom the plan belongs. This skill is critically important not only in the following dialogue/interview processes, but throughout the complete planning process.

- What is **"important to"** a person/family includes only what that person is "saying" with their words and with their behaviors. (Example: Many people/families have lived in circumstances where they were expected to say what others wanted them to say. If a person is saying what they think we want to hear, it is important to 'listen' to their behavior to help decide what is really being said, the underlying message of truth. We may need to use a symbolic "third ear" to hear fully and accurately.)

- What is **"important for"** people/families includes those things that need to be kept in mind for people/families regarding: Issues of health or safety and what others see as important for the person to be a valued member of their community (in relationships, school, work, etc.) [1] (**EXAMPLE**: A young adult with a cognitive disability may see "adventure", "new experiences", "cars", and "sports" as important TO him or her, while the parents may see "safety", "protection", and "security" as important FOR the young adult)

Why do this?

Finding the balance between "important to" and "important for" is the fundamental person-centered thinking skill. People/families in the public service system may be in circumstances where others exercise control over them. What is "important for" them is addressed while what is "important to" them is ignored or seen as what is done when time permits. [2]

- **Informal Services/Supports –** Every effort should be made to use these resources before resorting to the utilization of paid supports.

  a. **Personal Resources:** The person's own resources, such as special skills, capacities, or attributes, should be examined and included in the plan.
  b. **Natural Supports:** Natural supports include family, neighbors, co-workers, and friends of the individual/family's choosing. Existing supports should be included if applicable and new ones explored.
  c. **Community Resources:** Community resources are those that exist for any community member's use. Examples include church or faith-based organizations, Boy's or Girl's Clubs, YM or YWCA, special interest or civic groups, sports or any other group available to other community members. Opportunities to connect the individual/family to the community must be explored and offered.

- **Formal Services/Supports** – This is paid assistance provided by professionals or paraprofessionals in the publicly funded system of services who are qualified to provide the specified service.

(Please integrate the skill of finding the balance between "Important TO" and "Important FOR" throughout the planning process.)

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[1] Ibid, Chapter 1, page 20

[2] *Essential Lifestyle Planning for Everyone* by Michael W. Smull and Helen Sanderson, 2005, Chapter 1, page 21

III. PERSON-CENTERED PLAN INSTRUCTIONS

(Page 1 of PCP) – Header (Applies to first page only)

Name: *(Person's legal name)* **Preferred Name:** *(Enter the name that the person prefers to be called)*	**DOB:** (*mm/dd/yyyy)*	**Medicaid ID:** (*Enter identification noted on current Medicaid card)*	**Record #:** (*Enter the record number assigned by the LME)*
Person's Address: **(Street/mailing address)** **(City/State/Zip)**			**Telephone #:** (*Enter the telephone number of the person receiving services)*
Date of Plan: (*mm/dd/yyyy)* *(NOTE: Date of plan is the1st date of contact with the Qualified Professional who will complete the Introductory and/or Complete PCP.)*		**Allergies:** *(List known allergies of a critical nature)* 1. 2. 3. 4.	

- Check **Introductory Plan** box if this person is completely new to the mh/dd/sa system.

  - **Pages required for the Introductory Plan are**:

  1) **Action Plan** page(s) from the PCP.
  2) **Crisis Prevention/Crisis Response (Continuation)** page of the PCP (the 2nd page of the Crisis Plan reflecting contact and other information), including diagnostic information.
  3) **Signature Page** from the PCP including:
     a) Confirmation of Medical Necessity / Service Order dated signature
     b) Person Receiving Services dated signature (required when the person in his/her own legally responsible person.
     c) Legally Responsible Person dated signature when the person receiving services is not his/her own LRP.
     d) Person Responsible for the Plan dated signature.

- Check **Complete Plan** box if this plan follows an Introductory Plan, or is a plan for a person who has been receiving ongoing mh/dd/sa services.

  - **Required Content for a Complete PCP will include the following PCP pages:**

  1) Participants Involved in Complete Plan Development
  2) Personal Dialogue/Interview
  3) Family, Legally Responsible Person, Informal Supports Dialogue/Interview
  4) Service/Provider Dialogue/Interview
  5) Summary of Assessments and Observations
  6) Action Plan and Action Plan/Continuation
  7) Crisis Prevention/Crisis Response
  8) Crisis Prevention/Crisis Response (Continuation)
  9) Comments and Signatures

A. Participants Involved in Complete Plan Development – (Page 1)

(Page 1 of PCP) - Participants Involved in Complete Plan Development

Name: *(Enter the name of the individuals participating and providing any form of input into the development of the plan)-**The 1st box is reserved for the individual's participation.***

Relation/Agency: *(Enter the relationship and agency, if applicable, of each participant)*

Role: *(Check the box or boxes that define each participant's involvement in Plan development)*

☐ Facilitator of PCP/CFT meetings
☐ Participated in @ least 1 planning meeting
☐ Provided written input
☐ Telephone participation
☐ Invited, but no participation
☐ Other:

Other: (*List the individuals that the person/family would like to be a part of the planning process now or in the future.)*

- Include the consumer's name as a participant in the development of the plan.
- For all individuals receiving services, it is important to include people who are important in the person's life such as family, legally responsible person, professionals, friends and others identified by the individual/family (i.e. employers, teachers, faith leaders, etc.) in the planning process. These individuals can be essential to the planning process and help drive its success. The individual and/or the legally responsible person identify who will participate in the planning process, how and

B. Personal Dialogue/Interview – (Page 2)

(Page 2 of PCP) - Header

Name: *(Person's legal name)*	**DOB:** (*mm/dd/yyyy)*	**Medicaid ID:** (*Enter identification noted on current Medicaid card)*	**Record #:** (*Enter the record number assigned by the LME)*

- Text entered in the header will show up on the remaining pages of the PCP.
- To insert the text, click on (View) on your toolbar, then click (Header/Footer), then insert your text.

B. Personal Dialogue/Interview – (Page 2)

<u>This section must include what is important TO the person to whom this plan belongs.</u>

- Personal dialogue/interview is used to gather information and is an assessment of the different life areas, skill levels, family, education, work history, etc. This is how the relationship is developed and it starts with the information staff gathers and continues to add on as the relationship builds. Every contact is an opportunity to learn something new about the person and this information needs to be reflected.
- Provide as necessary, language and/or deaf/hard of hearing interpreters for the individual/family as required per Administrative Rule 10A NCAC 27D .0303, Informed Consent.
- Include issues related to the person's environment, culture, ethnicity and race as appropriate.
- The individual to whom this plan belongs may complete this section of the plan if so desired. If not, staff will document as closely as possible, the exact words shared.
  - Using the 3rd person in this section is preferable to possibly misquoting the person in the 1st person.
  - It takes a lot of skill to master the use of 1st person for this exercise. The plan writer should use 1st person as he/she becomes comfortable with it.
- In order to protect a person's health, safety, welfare, and the person's freedom, it is necessary to identify health and safety factors and to create supports and back up plans aimed at minimizing risk and promoting wellness. Risks should be addressed by helping a person look at ways to be safe within the choices made.
- **<u>Note</u>: Add/revise whenever there is new information about this person. Sign your name (no initials) and date next to the new information, each time you add/revise.**

(Page 2 of PCP) - Personal Dialogue/Interview

What has happened in my life this past year? (Include exciting, fun things as well as challenges and concerns)

Long Term Goals: (What are the things I want to accomplish in the next year? What are my hopes/dreams for the future?)

Strengths: (What am I good at doing? What do people admire about me? What are my talents/gifts?)

Preferences: What is important **TO** me: (What are the people/activities/things/places that matter to me in everyday life? What don't I want in my life?)

(Critical elements):

- *Issues that are important **TO** the individual/family must be recorded even if other people spoken with offer information that may conflict.*
- *This plan belongs to the individual who will receive the services. This is his/her personal section and must be reserved to record only that information determined to be important by this person.*
- *Often it is the people who know the individual the best (family, friends, and providers) who identify what is important **FOR** the individual. That information should not be recorded here, but documented in the Family/Legally Responsible Person/Informal Supports and/or Service/Support Provider dialogue/interview sections.*
- *For very young children, or individuals who don't use words to communicate, there may be family or others who know the person well enough that they can talk about what is important TO that person (NOT what they think is important FOR them). That information may be documented here, indicating who provided it.*

Needs: (What would I change about my life? What is not working in my life? What do I need in order to be an active part of my community? What do I need to be healthy and safe?)

Supports: What is important **TO** me? (What do others need to know or do to support me best in relationships, in things I like to do, in work or school and ways to stay healthy and safe?)

- ***Health and safety -** In order to protect a person's health, safety and, consequently the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.*
- ***Health and Wellness –** Overall healthcare and wellness issues should be addressed here.*
- *Include information here that is needed to complete the crisis plan.*

C. Family, Legally Responsible Person, Informal Supports Dialogue/Interview – (Page 3)

- Include issues related to the person's environment, culture, ethnicity and race as appropriate.
- Information should be gathered through a series of conversations with people important to the individuals and their families. The guiding questions on the form are not all inclusive.
- The legally responsible person may fill this out. Documentation on this page should reflect information given by the family member/s, guardian and informal supports providers participating in plan development.
- Critical elements to identify are what is important **TO** the person/family and what is important **FOR** the person/family.

*(NOTE: Often it is the people who know the individual the best (family, friends, providers) who can most clearly identify what is important **FOR** the individual. These issues can be related to health and safety concerns including for example, medical, psychiatric, social, and/or behavioral issues.)*

If the person does not want family members involved and the person is his/her own legally responsible party, indicate that on this page and do not complete further.

(Page 3 of PCP) – Family, Legally Responsible Person, Informal Supports Dialogue/Interview

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things he/she wants to accomplish in the next year? What are his/her hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

- *Draw information from any completed Strength's Assessments.*

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in his/her life?)

Needs: (What would this person change about his/her life? What is not working in his/her life? What does he/she need in order to be an active part of his/her community? What does he/she need to be healthy and safe?)

Supports: What is important **TO** this person? (What do others need to know or do to support them best in relationships, in things they like to do, in work or school and ways to stay healthy and safe?)

- ***Health and safety -*** *In order to protect a person's health, safety and, consequently the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.*
- ***Health and Wellness –*** *Overall healthcare and wellness issues should be addressed here.*
- *Include information here that is needed to complete the crisis plan.*

D. Service/Provider Dialogue/Interview – (Page 4)

- Include issues related to the person's environment, culture, ethnicity and race as appropriate.
- Information should be provided as outlined in the prompts for each section. The prompts should not be considered all inclusive.
- The person responsible for the plan/clinical home should fill this out after talking with applicable providers. Documentation should reflect information given by the services and supports providers participating in plan development.

(Note): Add/revise information whenever there is new information about this person. Sign your name (no initials) and date next to the new information, each time you add/revise.

(Page 4 of PCP) - Service/Provider Dialogue/Interview

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things he/she wants to accomplish in the next year? What are his/her hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

- *Draw information from any completed Strength's Assessments.*

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in his/her life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?

Supports: What is important **TO** this person? (What do others need to know or do to support them best in relationships, in things they like to do, in work or school and ways to stay healthy and safe?)

- ***Health and safety -*** *In order to protect a person's health, safety and, consequently the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.*
- ***Health and Wellness –*** *Overall healthcare and wellness issues should be addressed here.*
- *Include information here that is needed to complete the crisis plan.*

E. Summary of Assessments and Observations – (Page 5)

- A **Comprehensive Clinical Assessment** is a required element of the Completed PCP.
- The **Comprehensive Clinical Assessment may include**, but is not limited to:
  - T1023-Diagnostic Assessment
  - 90801-Clinical Evaluation/Intake
  - 90802-Interactive Evaluation
  - 96101-Psychological Testing
  - 96110-Developmental Testing (Limited)
  - 96111-Developmental Testing (Extended)
  - 96116-Neuropsychological Exam
  - 96118-Neuropsychological Testing Battery
  - H-0001-Alcohol &/or Drug Assessment
  - H-0031-Mental Health Assessment
  - Evaluation & Management (E/M) Codes
  - YP830-Alcohol &/or Drug Assessment-non-licensed provider (State $ only)
  - YP836-Mental Health Assessment-non-licensed provider (State $ only)

(Page 5 of PCP) - Summary of Assessments/Observations

ASSESSMENTS COMPLETED *(List the Comprehensive Clinical Assessments that have been completed for this individual)*	**RECOMMENDATIONS FROM ALL ASSESSMENTS** *(Enter recommendations made as a result of all completed assessments)*	**LAST DATE COMPLETED** *(Enter the most recent completion date for each assessment)*	**APPROXIMATE DUE DATE** *(If re-assessment is recommended, enter the projected due date for the re-assessment. If re-assessment is not recommended, enter "N/A")*
NC TOPPS (MH/SA only)		/ /	/ /
NC SNAP (DD only)		/ /	/ /
		/ /	/ /

ADDITIONAL ASSESSMENTS RECOMMENDED *(If the above assessments indicated that other assessments would be beneficial, list them here)*	**REASON FOR RECOMMENDATION** *(Enter recommendations made as a result of all completed assessments)*	**APPROXIMATE DUE DATE** *(Enter the projected completion date for the assessment)*	**DATE COMPLETED** *(Enter the date of the completed assessment)*
		/ /	/ /

(Page 5 of PCP) - Summary of Assessments/Observations

Recommendations for Services/Support/Treatment based on Assessments *(Use the information from each assessment to determine and enter the specific services, supports/interventions and treatment needed to achieve the desired outcome/s.*	Frequency: *(Indicate how often the service/support will be used to achieve the outcome)*	Duration: *(Indicate how long the service/support will be used to achieve the outcome)*	Target Date: *(Indicate the projected completion date for the service, support or treatment. Target dates may not exceed 12 months)*	State/Medicaid/ Health Choice *(Note whether the service to be used to achieve the outcome is Medicaid, Health Choice or State funded)*
1.			/ /	

Symptoms/Observations of this Person: *(Enter key symptoms and observations that will result in action plans)*

- ***Symptoms*** *are indicators of disorders or disease that cause a decrease in the ability to fully participate in daily activities or impair the ability to achieve a maximum quality of life. They are determined by formal assessments.*
- ***Observations*** *are those characteristics, qualities, actions that are representative of this person and his/her diagnosis.*
- ***Examples of some symptoms or observations are****, "is withdrawn", "hears voices", "has great difficulty in social situations", "destroys property", "is very angry", "unable to stay still", "talks about wanting to get high", etc.*

F. Action Plan/Continuation – (Page 6 & 7)

- Potential service, support, intervention and/or treatment options to meet the goals and needs of the individual/family are identified and discussed in collaboration with professionals and other service providers in the publicly funded system of services.
- The individual/family/legally responsible person must be fully informed of the rationale, evidence and risks of specific service, support/intervention and treatment options in order to make responsible choices based on the options presented.
- Care should be taken to assure that purchased or funded supports do not take the place of natural supports and community resources when they are available and appropriate to the need.
- **Health and safety –** In order to protect a person's health, safety and consequently the person's freedom, it is necessary to identify his/her health and safety risk factors. These factors should be recorded in the dialogue/interview sections of the plan. Ensure that supports and back up plans aimed at minimizing risk are addressed in the Action Plan, based on the information gathered. Risk should be addressed by helping a person look at ways to be safe within the choices made.
- Add additional copies of the Action Plan page as needed to address Long Range Outcomes, Symptoms/Observations, Short Range Goals, etc.

(Page 6 & 7 of PCP) - Action Plan and Continuation Page

Long Range Outcome: *(Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)*

(Based on the information gathered in the dialogues/interviews, in measurable terms, state the goal the person/family desires to achieve within a year and/or into his/her future.

Where am I now in relation to this outcome?

(Based on the information gathered in the dialogues/interviews, briefly describe the person's current status, skills and abilities related to the identified long range outcome and the person's current level of participation related to this outcome)

SYMPTOM/OBSERVATION #: *(For **Complete PCP**, list the symptom/observation from the Summary of Assessments/Observations page here that supports the need for the short range goal below. Use clinical judgment to recognize the relationships between the symptoms/observations and the short term goals. More than one goal may be developed for a single symptom/observation if necessary to fully address that need. For an **Introductory PCP**, list symptoms/observations based on preliminary knowledge.)*

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections for Complete PCP)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service & Frequency**
(Enter a person-centered measurable objective needed to achieve the long range outcome based on the Preferences and Supports sections of the dialogues/ interviews and including the "What's important to and for me" information)	*(Define the supports, interventions, services required to achieve the short range goal based on the Supports sections of the dialogues/interviews.*	*(Identify the individual(s) who will be responsible for implementing and documenting the progress toward the goal. When the responsible person is a paid provider, indicate in this box the position of the person. When possible, include the name of that individual as well)*	*(Identify the specific service/treatment to be used to address the goal and enter the frequency of that service.*

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
(Enter the date the team projects the person can achieve this goal. A target date may never exceed 12 months)	*(Enter the date progress towards the goal is reviewed)*	*(Based on the progress review, enter the status code as found below)*	*(If a goal is not achieved at the time of review, provide information justifying the reason the team determines to either continue or discontinue the goal).*
/ /	/ /		
/ /	/ /		

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

G. Crisis Prevention/Crisis Response - (Page 8)

A crisis plan includes supports/interventions aimed at preventing a crisis (proactive) and supports/interventions to employ if there is a crisis (reactive).

- A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to *address them*.
- A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond.
- Consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.
- It will be important that you know what positive skills the person has which can be elicited and increased at times of crisis. Redirection of energies towards exercising these skills can prevent crisis escalation. Positive behavioral supports may be relied upon as a crisis response.
- The crisis plan is an active and living document that is to be used in the event of a crisis. After crisis, person and staff should meet to discuss how well plan worked and make changes as indicated.

(Page 8 of PCP) - Crisis Prevention/Crisis Response

Symptoms/behaviors that may trigger the onset of a crisis (include lessons learned from previous crisis events):

- *Provide detailed information regarding known behaviors the person may demonstrate prior to going into crisis and what behavioral supports appear to be effective.*
- *Include environmental factors that contribute to the onset of the crisis and that should be controlled where possible. Strategies for controlling these environmental factors may be included in the plan.*
- *Include information learned from previous episodes that may allow a crisis intervention response resulting in de-escalation or crisis diversion.*
- *Incorporate information gathered from the Personal Dialogue/Interview, the Family/Guardian/Informal Supports Dialogues/Interviews and from the Service/Support Provider Dialogues/Interviews.*

Crisis prevention and early intervention strategies (List everything that can be done to help this person avoid a crisis):

- *Provide a detailed description of strategies that will be used to assist the person in avoiding a crisis. Strategies should be based on knowledge, information, and feedback from the person/family and other team members as well as strategies that have been effective in the past. Include opportunities for the person to exercise self-soothing skills developed and calming strategies such as consciously breathing deeply.*
- *Incorporate information gathered from the Personal Dialogue/Interview, from the Family/Guardian/Informal Supports Dialogues/Interviews and from the Service/Support Provider Dialogues/Interviews.*

(Page 8 of PCP) - Crisis Prevention/Crisis Response

Strategies for crisis response and stabilization (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

- *Provide a detailed description of strategies to be implemented to help the person/family stabilize during a crisis. Strategies should be based on knowledge, information and feedback from the person/family and other team members as well as effective intervention strategies identified during the person's day to day life and from previous crises and problem resolution.*
- *Steps should focus first on natural and community supports, starting with the least restrictive interventions.*
- *Incorporate information gathered from the Personal Dialogue/Interview, the Family/Guardian/Informal Supports Dialogues/ Interviews and from the Service/Support Provider Dialogues/Interviews.*
- *Positive behavioral supports and approaches other than calling in law enforcement to deal with a crisis should be sought. Law enforcement should be called as a last resort only. If calling law enforcement is part of the plan, law enforcement should be involved in the plan development and their agreement obtained ahead of time.*

Specific recommendations if person arrives at the Crisis and Assessment Service:

- *List specific detailed information on how to relate and/or respond to this person/family at the point of contact. Incorporate information gathered from the Personal Dialogue/Interview, the Family/Guardian/Informal Supports Dialogues/Interviews and from the Service/Support Provider Dialogues/Interviews in developing response recommendations.*

After the crisis, identify strategies for determining what worked and what did not work, and make changes to the plan:

- ***Identify strategies for determining, after the crisis, what worked and what didn't and changes that may be needed in the plan:*** *(Provide information as processed and assessed by members of the planning team, regarding effective and ineffective strategies. Make changes to the plan accordingly)*

H. Crisis Prevention/Crisis Response (Continuation) – (Page 9)

Contact List (Include names as applicable, relationship and direct phone numbers or extension.)

First Responder: Telephone #: Consent/Release of Information: ☐ Yes ☐ No

- ***Name****: Enter the name of the clinical home agency and if possible, the individual within the clinical home agency responsible for ensuring first response in case of emergency. For persons in residential services, that service provider is the clinical home and the first responder.*
- ***Telephone****: Enter the telephone number of the first responder/clinical home responsible for ensuring first response in case of emergency. Designate if after hours number.*
- ***Consent/Release of Information:*** *Indicate yes or no that legal consent to contact the first responder has been signed by the person or legally responsible party. Legal consent must be in place for the agency/person to be designated as first responder.*

Legally Responsible Person: Telephone #: Consent/Release of Information: ☐ Yes ☐ No

(If applicable)

- *When applied to an adult who has been adjudicated incompetent, this is a guardian;*
- *When applied to a minor, a parent, guardian, a person standing in loco parentis (in the place of the parent when there is verified intent for this person to provide long-term care for the identified minor), or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment;*
- *When applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney as prescribed in Article 3 of Chapter 32 of the General Statutes. [NC G.S.122C-3 (20)]*
- *Telephone: Enter the telephone number where the legally responsible person can be reached*

Natural/Community Supports:

Name: Telephone #: Consent/Release of Information: ☐ Yes ☐ No

- ***Name:*** *Enter the name(s) of the individual(s) providing natural/community supports to be contacted during a crisis.*
- ***Telephone:*** *Enter the telephone number where the identified individuals providing natural/community supports can be reached.*
- ***Consent/Release of Information:*** *Indicate yes or no that legal consent to contact the identified natural/community support has been signed by the person or legally responsible person. Legal consent must be in place for the agency/person to be contacted during a crisis.*

Professional Supports:

Name: Telephone #: Consent/Release of Information: ☐ Yes ☐ No

- ***Name:*** *Enter the name of the psychiatrist or other professional providing care to the individual and designated to be contacted during a crisis.*
- ***Telephone:*** *Enter the telephone number for the identified professional.*
- ***Consent/Release of Information:*** *Indicate yes or no that legal consent to contact the professional has been signed by the person or legally responsible party. Legal consent must be in place for the professional to be contacted during a crisis.*

Primary Care Physician: Telephone #: Consent/Release of Information: ☐ Yes ☐ No

- ***Name:*** *Enter the name of the physician responsible for the overall medical care of the person.*
- ***Telephone:*** *Enter the telephone number for the identified primary care physician.*
- ***Consent/Release of Information:*** *Indicate yes or no that legal consent to contact the primary care physician has been signed by the person or legally responsible person. Legal consent must be in place for the physician to be contacted during a crisis.*

(Page 9 of PCP) - Crisis Prevention/Crisis Response (Continuation)

Preferred Psychiatric Inpatient /Respite Provider: Telephone #:

Consent/Release of Information: ☐ Yes ☐ No

- ***Name:*** *Enter the name of the preferred inpatient psychiatric facility or the crisis respite provider as identified by the team.*
- ***Telephone:*** *Enter the telephone number for the psychiatric inpatient or respite provider.*
- ***Consent/Release of Information:*** *Indicate yes or no that legal consent to contact the preferred psychiatrist inpatient or respite provider has been signed by the person or legally responsible party. Legal consent must be in place for the provider to be contacted during a crisis.*

Other Professional Supports:

Name: _____ Telephone #: Consent/Release of Information: ☐ Yes ☐ No

- ***Name:*** *Enter the name of the individual(s) providing other professional supports who are to be contacted during a crisis.*
- ***Telephone:*** *Enter the telephone number of the individual(s) providing professional supports.*
- ***Consent/Release of Information:*** *Indicate "yes" or "no" that legal consent to contact the other individuals providing professional supports has been signed by the person or legally responsible party. Legal consent must be in place for these professionals to be contacted during a crisis.*

All Current Medications	**Dose:**	**Frequency:**	**Reason for Change:**	**Date**
(List the name of every current medication prescribed for the person. This includes psychiatric medications and all the other medications the person is taking. Update and revise list of medications whenever there is a change so that in the event of a crisis the information is correct. An update to the medication list alone will not constitute a revision to the plan.)	*(Enter the dosage of each medication)* ***Example:*** *The amount of medicine administered and/or taken.*	*(Enter the dosage frequency information as noted on the prescription)-* ***Example:*** *How often the medicine is administered and/or taken.*	*(Enter the reason for the update/revision)* ***Example:*** *New medication, terminated medication, new dose, new frequency, etc)*	*(Enter the date of each initial prescription)*

(Page 10 of PCP) - Crisis Prevention/Crisis Response (Continuation)

Advanced Directives: (Advance Directives allow you to plan ahead for care in the event that there are times that you are unable to speak for yourself).

☐ Yes ☐ No I have a Living Will. ☐ Yes ☐ No I would like one.
☐ Yes ☐ No I have a Health Care Power of Attorney. ☐ Yes ☐ No I would like one.
☐ Yes ☐ No I have an Advanced Instruction for Mental Health Treatment. ☐ Yes ☐ No I would like one.

- ***Advance Directives:*** *Enter yes or no to the existence of a living will, health care power of attorney or advance directives for mental health treatment. If the person has any of these, attach a copy. If the person does not have them, explain the options.*
  1. ***Living Will*** *- All competent adults have the right to make decisions in advance about issues such as life support when it is clear that death is imminent or a state of coma becomes permanent. With a living will in place, the legally responsible party can make sure that the person's wishes are honored.*
  2. ***Health Care Power of Attorney*** *- Also known as a durable power of attorney for health care, this document can be helpful when the person is unable to make medical decisions for him/herself. It may also be referred to as a health care proxy or a medical power of attorney. It names someone who represents the person's wishes. Unlike the living will, which usually is limited to terminally ill patients, this document applies whenever the person is unable to make medical decisions.*
  3. ***Advance Instruction for Mental Health Treatment*** *- [NC General Statute122C-72 (1)] Advance instruction for mental health treatment or advance instruction means a written instrument signed in the presence of two qualified witnesses who believe the person to be of sound mind at the time of the signing, and acknowledge that before a notary public. In this document, the person gives instructions, information, and preferences regarding mental health treatment.*

Emergency Contact or Next of Kin: *(Enter the person's choice of a person to contact in an emergency)*

Relationship to Person: *(Enter how the emergency contact is related to the person)*

Address: *(Enter the street or mailing address of the emergency contact)*

City/State/Zip: *(Enter the city, state and zip code for the street or mailing address of the emergency contact)*

Home Phone: *(Enter the telephone number for the residence of the emergency contact)*

Work Phone: *(Enter the telephone number of the worksite for the emergency contact, if applicable)*

Legally Responsible Person's Name: *(If applicable, enter the Legally Responsible person's name)*

Telephone Number: *(Enter the telephone number where the legally responsible person can be reached)*

If Legal Guardian Appointed: *(Attach a copy of any applicable supporting legal documents must be attached)*

Date of Legal Document: *(Enter the date noted on the legal guardianship document's specifying the date of appointment)*

Crisis Plan Distribution List (List contact information):

- *Enter the names of all individuals/agencies receiving copies of the crisis plan. There must be consent/release of information signed for each person listed.*

	(DSM* Code)	(Diagnosis)	(Diagnosis Date)
Axis I			/ /
Axis II			/ /
Axis III			/ /
Axis IV			/ /
Axis V			/ /

(*The Diagnostic & Statistical Manual of Mental Health Disorders IV-TR, 2000 organizes psychiatric diagnosis on 5 axes. They are listed below): **Axis I:** Major Mental Disorders: Developmental Disorders and Learning Disabilities
Axis II: Personality Conditions and Mental Retardation
Axis III: Any Non-Psychiatric Medical Condition
Axis IV: Social Functioning and how symptoms affect the person
Axis V: Global Assessment of Functioning (GAF) based on a scale of 100-0 for adults and/or the Children's Global Assessment Scale, also a 100-point scale

I. Comments and Signatures – (Page 11)

SIGNATURES

For Medical Necessity of Medicaid funded services:

- **A Licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner** must sign the plan indicating that requested services are medically necessary. (NOTE: A provider may not bill Medicaid for services until this signature is acquired.)
- This signature and the date of the signature are REQUIRED. The signature is authenticated when the designated professional signing enters the date next to his/her signature.
- The signature serves as the Service Order for services contained in the Person-Centered Plan.
- Enter the date on or before the annual review of medical necessity is due.

For Medical Necessity of State funded services:

- It is RECOMMENDED that a **licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner** sign the plan indicating that requested services are medically necessary. This will prevent the possibility of services being provided without a service order should the individual move from State-funded services to Medicaid.
- If a licensed professional listed above does NOT confirm medical necessity, it is then REQUIRED that the **person responsible for the plan/clinical home** sign the person-centered plan **in the third box on the Signature page,** confirming that medical necessity criteria is met for the services included in the plan.
- One of these signatures and the date of the signature are REQUIRED.
- The signature serves as the Service Order for state-funded services contained in the Person-Centered Plan. The signature is authenticated when the individual signing enters the date next to his/her signature.
- Enter the date the annual review of medical necessity is due.

(Page 11 of PCP) - Comments

Comments or Concerns on Plan by the person whose plan this is and/or the legally responsible person:

(The outcome of the planning process is intended to be consensus on the plan. A consensus implies that debate has taken place and that the plan is generally accepted. If the person/legally responsible party has comments or concerns with regard to the plan, they should be noted here)

Steps to address concerns:

(If comments or concerns are noted, enter the steps to address the concerns here.)

(Page 11 of PCP) - Signatures

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

My signature below confirms that medical necessity for services requested is present, and constitutes the Service Order(s):

Signature: _____ Date: ____/____/_____

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual review of medical necessity and re-ordering of services is due on or before: ____/____/_____

(Page 11 of PCP) - Signatures

Signature of person receiving services:

- The person receiving services is required to sign and date the plan indicating confirmation and agreement with the services and supports detailed in the plan and confirmation of choice of service provider(s) *if the individual is his/her own legally responsible party*. The signature is authenticated when the individual signing enters the date next to his/her signature.
- All individuals are highly encouraged to sign their own plans.
- A minor may and/or must sign the plan under the following conditions:
- If the minor is receiving mental health services as allowed in NC General Statute 90-21, the minor's signature on the plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.

Person Receiving Services:

- I confirm and agree with my involvement in the development of this person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for my plan.

Signature:_____ Date: ____/____/_____

(Required when person is his/her own legally responsible person)

- **<u>The following signatures confirm the involvement of individuals in the development of this person-centered plan. All signatures indicate agreement with the services/supports to be provided</u>.**
- **<u>For state-funded services, if the first signature box on this page is not completed, the signature of *the Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.</u>**

Legally Responsible Person Signature:_____ Date: ____/____/_____

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____ Date: ____/____/_____

(Required)

Other Team Member Signature: _____ Date: ____/____/_____

Other Team Member Signature: _____ Date: ____/____/_____

Annual review of medical necessity and re-ordering of services is due on or before:

Date: ____/____/_____

(Page 11 of PCP) - Signatures

For **minors receiving outpatient substance abuse services**, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (NC General Statute 90-21.5), the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.

For an **emergency admission to a 24-hour facility, per NC General Statute 122C- 223(a)**, "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own application." In this case, the minor's signature on the plan would be sufficient.

For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(b)**, "within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted." Once contacted, the legally responsible person is required to sign the plan.

For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(c)**, "If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services." In this case, the individual designated from juvenile protective services shall sign the plan.

***NOTE**: For minors receiving substance abuse services in a non-emergency admission to a 24-hour facility, both the legally responsible person and the minor are required to sign the plan.*

***NOTE**: Within Substance Abuse Non-Medical Community Residential Treatment, Residential Recovery Programs for women and children the Person-Centered Plan shall also include goals for the parent-child interaction.*

Legally Responsible Person: The legally responsible person, if not the person receiving services, signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED. A provider may not bill Medicaid for services until this signature is acquired.)

Person Responsible for Plan: The qualified professional representing the person's *clinical home* and responsible for the plan development signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED. : A provider may not bill Medicaid for services until this signature is acquired.)

Other Team Members: Other team members have the option to sign and date the plan confirming participation and agreement with the services and supports detailed in the plan. Participation is defined on page 2, *Participants Involved in Plan Development*.

If state-funded services were not ordered/medical necessity not confirmed per the recommended Medicaid requirement above, the qualified professional representing the person's *clinical home* signature will also constitute the service order and is REQUIRED.

If the Personal Responsible for the Plan has ordered state-funded service(s), enter the date that the Annual Review of medical necessity and re-ordering of State-funded services is due.

NOTE:

1. The date that the person/legally responsible party and the person responsible for the plan/clinical home sign the plan is the date the person-centered plan is considered valid. If not signed on the same date, the latest date indicated is the date the plan is considered valid. This "validity" does not indicate that the service order also has a valid signature. All three signatures must be in place and valid before billing of services may occur.
2. If the legally responsible party is not available to sign the plan, an explanation and verification of efforts to obtain the signature must be documented in the service record. The signature must be obtained at the earliest possible date, but the plan will be considered valid while the documented effort takes place.

J. Plan Update/Revision Requests – (Page 12)

(Page 11 of PCP) - Header

Name: *(Person's legal name)* **Preferred Name:** *(Enter the name that the person prefers to be called)*	**DOB:** (*mm/dd/yyyy)*	**Medicaid ID:** (*Enter identification noted on current Medicaid card)*	**Record #:** (*Enter the record number assigned by the LME)*
Person's Address: **(Street/mailing address)** **(City/State/Zip)**			**Telephone #:** (*Enter the telephone number of the person receiving services)*
Date of Plan: (*mm/dd/yyyy)* *(NOTE: Date of plan is the1st date of contact with the Qualified Professional who will complete the Introductory and/or Complete PCP.)* **Type of Plan:** *(Check the box that applies and enter)* ☐ Update Revision ☐ Update Revision Including Annual Review of Medical Necessity		**Allergies:** *(List known allergies of a critical nature)* 1. 2. 3. 4.	

- Check **Update/Revision** if this is an update/revision to a previous PCP. Enter the date of the update/revision. Plans must be reviewed and updated/revised by the person responsible for the plan/clinical home and the individual/family/legally responsible party:
  - When the individual's needs change.
  - On or before assigned target dates (not to exceed 12 months)
  - When a service provider changes
- Check **Update/Revision, including annual review of Medical Necessity** if this is the annual review of medical necessity/re-ordering of all services. Enter the date.
  - **For Medicaid funded services**, the date the plan is signed by the appropriate professional confirming medical necessity and ordering services is the date on which the annual review is based.
  - **For State funded services**, the date the plan is signed by either the licensed professional per Medicaid requirements OR the person responsible for the plan/clinical home is the date on which the annual review is based.

Long Range Outcome:

In measurable terms, state the person-centered goal the individual desires to achieve within a year or into his/her future.

Where am I now in relation to this outcome?

Briefly describe the person's current status, skills and abilities related to the identified long range outcome and the person's current level of participation related to this outcome.

(Page 12 of PCP) - Plan Update/Revision Requests

SYMPTOM/OBSERVATION #: *(List the symptom/observation from the Summary of Assessments/Observations page here that supports the need for the short range goal below. Use clinical judgment to recognize the relationship between the symptoms/observations and the short term goals. More than one goal may be developed for a single symptom/observation if necessary to fully address that need.*

Short Range Goal (Taken from Preferences & Supports Sections ("What's important TO & FOR me")	**Support/Intervention to Reach Goal (Taken from Supports Sections)**	**Who will Provide Support/Intervention/ Service?**	**Support/Service**
Enter a person-centered measurable objective needed to achieve the long range outcome based on the Preferences and Supports sections of the interviews and including the "What's important to and for me" information.	*Define the supports/interventions/services required to achieve the short range goal based on the Supports sections of the interviews.*	*Identify the individual(s) who will be responsible for implementing and documenting the progress toward the goal. When the responsible person is a paid provider, indicate the position of the person in this box. When possible, include the name of that individual as well.*	*Identify the specific service/treatment to be used to address the goal and enter the frequency of the service.*

Target Date (Not to exceed 12 months.)	**Reviewed Date**	**Status Code**	**Justification for Continuation/Discontinuation of Goal**
Enter the date the team projects the person can achieve this goal. A target date may never exceed 12 months.	*Enter the date progress towards the goal was reviewed*.	*Based on the progress review, enter the status code.*	*If a goal is not achieved at the time of review, provide information justifying the reason the team determines to either continue or discontinue the goal.*
/ /	/ /	*(Enter the Status Code)*	*(Enter the Justification of Continuation/Discontinuation of Goal)*

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

K. Plan Update/Revision Signature - (Page 13)

(Page 13 of PCP) - Plan Update/Revision Signatures

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

<u>If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s):</u>

Signature: _____ Date: ____/____/_____

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual Review of medical necessity is due on or before: Date: ____/____/_____

(Page 13 of PCP) - Plan Update/Revision Signatures

Person Receiving Services:

- I confirm and agree with my involvement in the development of this update/revision to my person-centered plan. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time by contacting the person responsible for my plan.

Signature:_____ Date: ____/____/_____

(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this update/revision to the person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For State-Funded services, if the first signature box on this page is not completed AND this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, the signature of the *Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature:_____ Date: ____/____/_____

(Required, if other than the individual)

(The legally responsible person, if not the person receiving services, signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED.)

Person Responsible for the Plan Signature: _____ Date: ____/____/_____
(Required)

- *The qualified professional representing the person's clinical home and responsible for the plan development signs and dates the update/revision confirming involvement and agreement with the services and supports detailed. This signature is REQUIRED.*
- ***For state-funded services**, if the update/revision includes new services or is the annual review of medical necessity/re-ordering of services AND the Medicaid recommended signatures were not obtained, the qualified professional representing the person's clinical home signature will also constitute the service order and is REQUIRED.*

Other Team Member Signature: _____ Date: ____/____/_____

(Other team members have the option to sign and date the plan confirming participation and agreement with the services and supports detailed in the plan)

Annual Review of medical necessity and re-ordering of State-funded services is due on or before:

Date: ____/____/_____

(Page 13 of PCP) - Signatures/Medical Necessity

Service Order/Confirmation of Medical Necessity for Medicaid Services

- Medical necessity is confirmed via signature of the appropriate professional on the Person-Centered Plan. The signature is authenticated when the individual signing enters the date next to his/her signature.
- Confirmation of medical necessity constitutes the Service Order.
- Services must be ordered/medical necessity confirmed by a licensed physician, licensed psychologist, licensed physician's assistant, or a licensed family nurse practitioner, unless otherwise noted in the Service Definition.
- There must be an annual review of medical necessity/re-ordering of services. The first use of this Person-Centered Planning document begins the requirement for the annual review/re-ordering of services, based on the dated signature of the professional ordering the services.

Service Order/Confirmation of Medical Necessity for State-funded Services.

- If a professional noted above does not sign confirming medical necessity and ordering the services, it is then REQUIRED that the **person responsible for the plan/clinical hom**e sign the person-centered plan confirming that medical necessity criteria is met for the services included in the plan. *(Note: The person responsible for the plan/clinical home must sign the plan even if the service is ordered per the Medicaid requirement. In this case, the signature is required but does not constitute the service order.)* The signature is authenticated when the individual signing enters the date next to his/her signature.

Confirmation of medical necessity constitutes the Service Order.

There must be an annual review of medical necessity/re-ordering of services.

- The first use of this Person-Centered Planning document begins the requirement for the annual review/re-ordering of services, based on the dated signature of the professional ordering the services.

(Page 13 of PCP) - Plan Update/Revision Requests

Check boxes and enter date exactly as done on (Page 11), Plan Update/Revision Requests

1. **For Medicaid funded services:**
   - **When the Update/Revision includes a *new service(s)***, a licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner must sign the Update/Revision indicating that requested service(s) are medically necessary. **The dated signature serves as the Service Order(s).**
   - **When the Update/Revision is the *Annual Review of Medical Necessity***, a licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner must sign the Update/Revision indicating that the services contained in the plan are medically necessary. **The dated signature serves as the annual review/re-ordering of services.**
   - This signature and the date of the signature are REQUIRED. The signature is authenticated when the individual signing enters the date next to his/her signature.
   - **Enter the date** on or before which the next annual review of medical necessity is due.

2. **For State funded services:**
   - **When the Update/Revision includes a *new service(s),*** it is RECOMMENDED that a licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner sign the Update/Revision indicating that the services contained in the plan are medically necessary. This signature serves as a Service Order and will prevent the possibility of services being provided without a service order should the individual move from State-funded services to Medicaid.
   - **When the Update/Revision is the *Annual Review of Medical Necessity***, it is RECOMMENDED that a licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner sign the Update/Revision indicating that the services contained in the plan are medically necessary. **The dated signature serves as the annual review/re-ordering of services.** It will prevent the possibility of services being provided without a service order should the individual move from State-funded services to Medicaid.
   - If the recommended signatures above are not obtained, it is REQUIRED that the **person responsible for the plan/clinical home** sign the Update/Revision indicating the medical necessity has been met and ordering the service(s). *[Note: The person responsible for the plan/clinical home must sign the update/revision even if the service(s) is ordered per the Medicaid requirement above. In this case, the signature confirms involvement and agreement with the services and supports detailed in the update/revision, but does not constitute the service order.]*
   - **Enter the date** on or before which the next annual review of medical necessity is due.

Submit this Plan Update/Revision Signature page and the Plan Update/Revision page (page 11) as required to the identified service authorization agency.

NOTE:

1. The date that the person/legally responsible party and the person responsible for the plan/clinical home sign the plan is the date the person-centered plan is considered valid. If not signed on the same date, the latest date indicated is the date the plan is considered valid. This "validity" does not indicate that the service order also has a valid signature. All three signatures must be in place and valid before billing of services may occur.
2. If the legally responsible party is not available to sign the update/revision, an explanation and verification of efforts to obtain the signature must be documented in the service record. The signature must be obtained at the earliest possible date, but the update/revision will be considered valid while the documented effort takes place.